pennsylvania
DEPARTMENT OF HUMAN SERVICES

**Office of Medical Assistance Programs**
**Fee-for-Service, Pharmacy Division**
**Phone 1-800-537-8862 Fax 1-866-327-0191**

# NSAIDs PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **NSAIDs** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

| PRIOR AUTHORIZATION REQUEST INFORMATION | | PRESCRIBER INFORMATION | |
|---|---|---|---|
| ☐New request ☐Renewal request | Total # pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | State license #: | |
| LTC facility contact/phone: | | NPI: | MA Provider ID#: |
| **BENEFICIARY INFORMATION** | | Street address: | |
| Beneficiary name: | | Suite #: | City/state/zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

**Non-preferred medication requested** *(all ketorolac requests (including Sprix nasal spray) – use "Ketorolac Prior Authorization Form")*:

| | | | |
|---|---|---|---|
| ☐Arthrotec tablet | ☐etodolac tablet | ☐meclofenamate capsule | ☐piroxicam capsule |
| ☐Cambia powder | ☐etodolac ER tablet | ☐mefenamic acid capsule | ☐Tivorbex capsule |
| ☐Celebrex capsule | ☐Feldene capsule | ☐Mobic tablet | ☐tolmetin capsule |
| ☐Daypro tablet | ☐fenoprofen capsule | ☐Nalfon capsule | ☐tolmetin tablet |
| ☐diclofenac potassium tablet | ☐fenoprofen tablet | ☐Naprelan CR tablet | ☐Vimovo tablet |
| ☐diclofenac/misoprostol tablet | ☐Indocin rectal suppository | ☐Naprosyn EC tablet | ☐Vivlodex capsule |
| ☐diclofenac sodium 1% topical gel | ☐Indocin suspension | ☐naproxen sodium CR/ER TBMP | ☐Zipsor capsule |
| ☐diflunisal tablet | ☐indomethacin ER capsule | ☐naproxen sodium Rx tablet | ☐Zorvolex capsule |
| ☐Duexis tablet | ☐ketoprofen ER capsule | ☐oxaprozin tablet | ☐_____ |
| ☐etodolac capsule | ☐Lodine tablet | ☐Pennsaid 2% pump | |

| Strength: | Directions: | Quantity: | Refills: |
|---|---|---|---|
| Diagnosis: | | Dx code (required): | |

1. Has the beneficiary tried and failed, or have a contraindication or intolerance to, any of the following preferred NSAIDs?

| | | |
|---|---|---|
| ☐celecoxib capsule | ☐indomethacin IR capsule | ☐naproxen OTC cap/tab |
| ☐diclofenac sod tablet (DR, EC, ER) | ☐ketoprofen IR capsule | ☐naproxen suspension |
| | ☐ketorolac tablet | ☐naproxen sodium DS tab |
| ☐diclofenac 1.5% topical solution | ☐meloxicam tablet | ☐sulindac tablet |
| ☐Flector patch | ☐nabumetone tablet | ☐Voltaren 1% gel |
| ☐flurbiprofen tablet | ☐naproxen Rx (tab, DR tab, EC tab) | |
| ☐ibuprofen OTC/Rx | | |

☐Yes – *Submit all supporting documentation of drug regimen and treatment outcome.*
☐No

2. ***Requests for non-preferred TOPICAL NSAIDs:*** Why is the transdermal route of NSAID administration medically necessary for the beneficiary? *Include explanation in space provided and submit documentation supporting request.*

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

| **Prescriber Signature:** | **Date**: |
|---|---|